Illinois Health Benefits Exchange Key Issues

To: Members of the Health Reform Implementation Council

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Thank you for the opportunity to provide comments on the key issues involved in initiating a Health Benefits Exchange in Illinois. All of the questions are listed below with our responses to many of them. Those questions that were beyond the scope of our work as local mental health authorities are marked with N/A.

Functions of a Health Benefit Exchange

1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

Not being familiar with all of the facets of an HHS operated Exchange, it is difficult to compare, but the advantage of Illinois operating its own exchange is a better understanding of state and local issues and experience in working within the Illinois political system and the health and human services infrastructure. Local providers and other community-based entities can serve as social marketers to help communicate information about the Exchange to the target population, especially for those with complex needs.

2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

N/A

3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?

The Exchange would definitely have to function as more than a clearinghouse in order to realize the benefits of a state-operated Exchange. Having control over the number of benefit plans and level of quality, negotiating benefits and premiums, being able to require or reward aspects of a health plan (e.g., electronic health records, health home models, accountable care organizations), and overseeing coordination of care as individuals move from one subsidy program to another are all benefits for individuals who will be covered by Medicaid or the Health Insurance Exchange, and the State will benefit by having a cost effective Exchange and a healthy citizenry.

4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

Although permitting any willing provider may encourage greater competition, the board for the Exchange should evaluate information on premium increases prior to implementation from any willing provider, and consider recommendations provided by the Department of Insurance when determining whether to make the health plan available through the Exchange. Additionally, the Board should take into account the following information in selecting and retaining health plans in the Exchange: Claims payment policies and practices; periodic financial disclosures; data on enrollment and disenrollment; data on the number of claims that are denied; data on rating practices; information on cost sharing and payments with respect to any out-of-network coverage; information on enrollee and participant rights under Title I of the federal act and according to the Mental Health Parity Law.

Structure and Governance

1. If Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

Because the Governor's office and the critical state agencies are fully engaged in implementing Health Reform, it would work well for Illinois to operate its own Exchange in an existing state agency, with the Department of Insurance as the most likely department to house the Exchange. California's model of an independent or quasi-state agency is also a possibility for Illinois. The buy-in from the Governor ensures state priorities will be met and a division of an existing state agency or an independent state agency allows easier coordination between state and federal entities, and a high level of accountability and transparency. The cons are that this structure is not as autonomous as an independent not-for-profit, it is most influenced by the political environment, and has more tedious procurement and human resources regulations. It is, therefore, important to have an independent governing board with representatives from the local and private sectors.

Following the California model, the governing board should be composed of the Secretary of Human Services and at least four other members appointed by the Governor and the Legislature to include the Directors of Healthcare and Family Services and Insurance, at least one representative from county government, and preferably representatives from public health and behavioral health local authorities. The board of the Exchange would be responsible for applying for and receiving federal funds for purposes of establishing the Exchange. The Director of Insurance would be responsible for reviewing an Internet portal developed by the Department of Health and Human Services and to jointly develop and maintain with HFS and DHS an electronic clearinghouse of coverage available in the individual and small employer markets if the federal Internet portal does not adequately achieve certain purposes (e.g., established outcomes and ability to track data, analyze and report outcomes.) Other stakeholders, first and foremost, the individuals who will be covered by the Health Insurance Exchange should have the opportunity to attend meetings of the board and provide input.

2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

Using the California Exchange Board model, a board would consist of at least five members who are residents of Illinois with 4-year appointment terms for the Governor appointees, and 2 or 3-year terms for

the legislature appointments to set up staggered terms. Each person should have demonstrated and acknowledged expertise in at least two of the following areas: 1) Individual health care coverage; 2) Small employer health care coverage; 3) Health benefits plan administration; 4) Health care finance; 5) Administering a public or private health care delivery system; and 6) Purchasing health plan coverage. Two board members should also have behavioral health experience in two of these areas.

Appointing authorities should consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise. In making appointments to the board, the appointing authorities should take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of Illinois. No board member may represent a carrier or other insurer, an agent or broker, a health care provider, a health care facility or health clinic, or a trade association of the aforementioned while serving on the board or on the staff of the Exchange.

The Exchange Board should hire an executive director to organize, administer, and manage the operations of the Exchange. The director would, in coordination with the Insurance Commissioner, review the Internet portal developed by the Secretary of Health and Human Services to examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers to facilitate fair and affirmative marketing of all individual and small employer products. As mentioned previously, if the Internet portal is not adequate, they would jointly develop and maintain an electronic clearinghouse to achieve those purposes, including routinely monitoring individual and small employer benefit filings and complaints submitted by individuals and small employers to their respective departments.

The External Market and Addressing Adverse Selection

1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

Some of the changes may have to occur in phases. Opening up the market may provide for faster acceleration of improvement processes, but more federal guidance is needed. One possibility is to require that health care service plans and health insurers issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, and not on risk selection.

2. What other mechanisms to mitigate "adverse selection" (i.e. requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

Federal guidance is needed on risk adjustment to ameliorate the problem of adverse selection, but one alternative is requiring identical products inside and outside the exchange. Another possibility is rewarding or encouraging high value plans that include features such as medical homes and accountable care organizations. A review/ appeals board should also be in place. The problem of adverse selection is of particular concern to the population we serve – these individuals will be more likely to fall under the 400% FPL AND have two or more chronic conditions, including mental illness and substance use disorders. We are concerned that one or both of these diagnoses will not be treated equally to other chronic conditions such as diabetes, heart disease or cancer.

3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

There is no particular state's model that comes to mind, however, in our research to date on other states' Health Insurance Exchange initiatives, perhaps every state is creating its own hybrid model!

4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

Generally, the same rules should apply to plans sold inside and outside an exchange, but there must be room for exceptions, as indicated by California's model.

5. What rules (if any) should the State consider as part of establishing the open enrollment period?
N/A

6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?
N/A

7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?
N/A

Structure of the Exchange Marketplace

1. Should Illinois operate one exchange or two separate exchanges for the individual and small group markets? Why?

At least to begin, Illinois should establish the Small Business Health Options Program, separate from the activities of the board related to the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market. There may be different barriers in small group markets that need to be overcome before lumping them together with individual markets. If it goes smoothly, the transition to combine the markets could take place sooner.

2. If there will be separate markets and separate exchanges, how large must the pools within these markets be to ensure stable premiums for both?
N/A

3. What should the Illinois definition of small employer be for initial Exchange participation in 2014?

Illinois should use the federal definition for initial Exchange participation.

4. Should Illinois consider setting any conditions for employer participation in the shop Exchange (e.g. minimum percent of employees participating, minimum employer contribution)?

It may further complicate a process that is already quite complex to set any additional conditions at the beginning.

5. Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?

If the Exchange is running smoothly and the infrastructure allows for increased participation, Illinois should permit large group employers to participate.

6. Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?

The Exchange should begin with one statewide system. Specialization by region or expanding into a multi-state exchange could be considerations for the future. Smaller states may be able to create regional or multi-state exchanges immediately because of their smaller population and geographical area. The only potentially regional exchange component that could be implemented at the beginning is through the Information Technology Framework project, if this initiative is funded.

Self-Sustaining Financing for the Exchange

1. How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

Assess a reasonable charge on the qualified health plans offered by carriers to support the development, operations, and prudent cash management of the Exchange. Carriers still must charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange. A portion of premiums from private and public plans could also help finance the Exchange's operations.

2. What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?

Given Illinois' $13 Billion deficit, it cannot afford to implement the Health Insurance Exchange without federal support during the initial years.

3. Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?
N/A

Eligibility Determination

1. How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

Medicaid and Health Insurance should be streamlined into a "front door" approach that includes the spectrum of subsidies for individuals and families up to 400% FPL with a single entry point and one form to apply for all applicable state subsidy programs. Behind the scenes, the information provided would be transferred to the appropriate system. The individual is then enrolled in any applicable public program determined through screening of the application by the Exchange. Public and private payers, providers and consumers would all be able to retrieve the personal electronic health record. This will require considerable information technology development and integration across systems and funders.

Determination of benefits should be done on the Exchange's and/or the insurance carriers' websites. The amount of the individual's cost sharing, e.g., deductibles, copayments, and coinsurance, using a standardized comparative plan format with assigned ratings, should be available to individuals via website and toll-free telephone hotline. An electronic calculator to determine the actual cost of coverage after the application of any premium tax credit should also be available on the websites.

In addition, Illinois should establish the navigator program to: (1) Conduct public education activities to raise awareness of the availability of qualified health plans; (2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions; (3) Facilitate enrollment in qualified health plans; (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under that plan or coverage; and (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

2. When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

Illinois should structure adequate physician rates that provide incentives to continue providing care to a publicly funded population.

3. What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

Patient-centered medical homes, negotiation on behalf of large groups of individuals and businesses, and the auction of plan slots will ensure coordination of eligibility, enrollment and affordability.

As the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange is determined, it will be important to coordinate that process with the state and local government entities administering other health care coverage programs in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

Stakeholder Involvement is another important aspect in maximizing care coordination. While Illinois already has buy-in from the Governor and key state agencies, the General Assembly, carriers, providers, consumers, and local governmental agencies will need to be more informed and invested in this system transformation. The Health Reform Implementation Council has done well in inviting stakeholders to public meetings and requesting comment. Other strategies for achieving this goal are to hold meetings in communities, invite interest groups to focus on specific exchange issues, and enlist patient navigators.

4. Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?

Yes, and the basic health plan should contain components of Medicare and Medicaid coverage as stated in federal guidelines and must include mental health/substance abuse parity.

Please remember that community behavioral health funders and agencies are important partners for enrolling hard-to-reach populations.